5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal regulations which would impact upon such costs. A description of current add-ons is included in Appendix 1 of this plan.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.

2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.

3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.

5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

   In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was $.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of $.117 ($.10 times 14 months, divided by 12 months) to

compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.

7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.

8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities) will be reimbursed at the 60th percentile, while ICF/DD-H and N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in distinct parts of acute care hospitals shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

11. Subacute services which are provided in freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. Transitional inpatient care is reimbursed based on a model rate in accordance with Report No. 01-95-06 contained as Supplement 3 to SPA 96-001 and Section V.A. of this State Plan.

14. Each year the current rate for NF-A 100+ bedsize will be increased by the

same percentage of increase received by other NF-level As. The term percentage increase means the average increase, weighted by patient days.

F. Notwithstanding paragraphs A through E of this Section, prospective rates for newly licensed DP/NF-Bs shall be based on the facility's historical costs of providing NF-B services regardless of ownership or licensure. A facility's historical costs shall be established from cost reports pursuant to Supplement 1 of this State Plan.

For DP/NF-Bs with historical costs as a licensed freestanding NF-B, the Department shall establish a prospective DP/NF-B rate based on the freestanding NF-B cost report. If the newly licensed DP/NF-B has reported costs as both a freestanding NF-B and DP/NF-B, the Department shall establish the facility's historical-costs basis by combining the freestanding NF-B and DP/NF-B total patient days and costs. Newly licensed DP/NF-Bs shall receive prospective rates based on available freestanding NF-B cost reports until the Department uses the consolidated hospital DP/NF-B cost report and/or audit in the appropriate rate study.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

G. Subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the subacute facility's projection of their total patient days and costs, as approved by the Department. When actual subacute audit report data becomes available, interim rates will be retroactively adjusted to the subacute facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only subacute providers participating in the program as of June 1st will be included in the rate study.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When the State adopts a new service or significantly revises an existing service, the

rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study.

C. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

VI. PUBLIC CONSIDERATION

A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.

1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.

2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.

3. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES

PATIENT ACUITY LEVELS	*ORGANIZATION TYPE*	*No. of Beds*	*Geographical Location*	*Reimbursement Basis*
NF LEVEL B (EXCEPT SUBACUTE, PEDIATRIC SUBACUTE, and TRANSITIONAL INPATIENT CARE	-Distinct part NF	All	Statewide	*
	-Freestanding NF	1-59	Los Angeles Co.	Median
		1-59	Bay Area**	Median
		1-59	All Other Counties	Median
		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
PEDIATRIC SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
TRANSITIONAL INPATIENT CARE:				
REHABILITATIVE	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
MEDICAL	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NF LEVEL A	-All	1-99	Los Angeles Co.	Median
		1-99	Bay Area**	
		1-99	All Other Counties	Median
		100+	Statewide	***
ICF/DD	-All	1-59	Statewide	60th percentile
		60+	Statewide	60th percentile
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
RURAL SWING-BED NF LEVEL B SERVICES	-Rural acute hospitals	All	Statewide	Median

* DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.

** Bay area is defined as San Francisco, San Mateo, Marin, Alameda, Santa Clara, and Contra Costa counties.

*** Current rate increased by the same percentage rate as received by other NF level As.

ADD-ONS TO CURRENT RATE METHODOLOGY

- Increase in Licensure Fees - Every July, license fees are modified by the Department's Licensing and Certification Division to reflect the cost of that function. The cost of prior licensing fees are deleted from the projected cost and the new licensing fees are added into the projected cost.

- Minimum Data Set - An amount was added to the rates for skilled nursing facilities, subacute facilities and intermediate care facilities, to cover costs of implementing the Minimum Data Set, which requires all of these facilities to electronically transmit certain long term care data items to the State. This add-on will continue until such costs are reflected in facility cost reports.

- Workplace Violence Guidelines - An amount was added to the Medi-Cal rates for training costs associated with guidelines adopted by the California Department of Industrial Relations, Division of Occupational Safety and Health that dealt with violence in the workplace. This add-on is described in report number 01-96-05, Study to Determine The Cost to Comply With Workplace Violence Guidelines and will terminate when the costs are reflected in the cost reports.

- Minimum Wage - An amount was given for freestanding nursing facilities (NF-Bs), intermediate care facilities (NF-As), intermediate care facilities for the developmentally disabled (ICF/DDs), intermediate care facilities for the developmentally disabled-habilitative (ICF/DD-Hs) and intermediate care facilities for the developmentally disabled-nursing (ICF/DD-Ns), to cover the increased salaries, wages and benefits costs incurred by these facilities due to the increase in the federal minimum wage on October 1, 1996, and the increase in the State minimum wage on March 1, 1997. This add-on is described in Long Term Care Minimum Wage Study, report number 01-97-01.

  In addition, components were also added for the federal minimum wage increase effective September 1, 1997, the increase in the California minimum wage which will take effect March 1, 1998. Details of the methodology for these increases are explained in The Long Term Care Minimum Wage Study, report number 01-97-06.

  These add-ons include a component to reimburse the indirect costs of avoiding wage compaction resulting from the minimum wage increases.

  These add-ons will terminate when all costs for the minimum wage increases are reflected

in the cost reports.

- Life Quality Assessments - The Department of Developmental Services implemented new legislation requiring assessing and monitoring of clients in ICF/DD, ICF/DD-H and ICF/DD-N facilities to determine the life quality offered to such clients. An amount was added to the 1998-99 rates for these facilities to meet staff costs for these ongoing activities. This add-on will continue until such costs are included in facility cost reports.

- Criminal Background Checks – An add-on to cover costs of rolling and processing fingerprint cards for background checks on direct care staff at ICF/DD and ICF/DD-N facilities. This add-on is described in the Department's report number 01-99-02 and will continue until such costs are reflected the cost reports.

- Bloodborne Pathogen – An add-on to reimburse facilities for a State mandate requiring monitoring and reporting of needlestick injuries and conversion by the industry to new safer needle technology to avoid spread of bloodborne pathogens. This add-on is described in the Department's report number 01-99-03.

- Drug Disposal – This add-on reimburses added costs of transportation and incineration of outdated or leftover drugs and medications. The add-on will continue until such costs are included in the cost reports and the calculation is included in the Department's report number 01-99-06.

- Wage Pass-Through – An add-on to provide long-term care facilities funding to pass through a wage increase to direct care staff(registered nurses, licensed vocational nurses and nurse assistants). The add-on does not apply to transitional care provided by acute care hospitals in their acute beds. This will continue until costs are fully reflected in the cost reports. Details of this add-on are in the Department's report number 01-99-07.

- Increase Minimum Nursing Hours to 3.2 – Requires NF-Bs and DP/NF-Bs to increase the minimum numbers of direct nursing hours per patient day to 3.2 and removes the doubling factor for licensed nursing hours when computing the number of hours of direct care that a facility provides. The add-on calculation for this change is described in the Department's report number 01-99-08.

(f) The development of alternative standards for beneficiary eligibility and copayment under Medi-Cal.

(g) The development of a method of response to temporary deficits in the Medi-Cal program that will both control expenditures and, to the extent possible, preserve the availability to beneficiaries of essential health services.

(Added by Stats.1983, c. 960, § 7.)

Article 5.3

AUDIT, APPEAL, AND RECOVERY OF OVERPAYMENTS

Section

Article 5.3 was added by Stats.1977, c. 1046, p. 3172, § 6.

Operative effect

Chapter to remain operative during times federal aid available, see § 14020.

Code of Regulations References

Health care services, provider audit appeals, see 22 Cal. Code of Regs. 51016 et seq.

§ 14170. Audits; controls; cost reports; corrections; payroll records; maintenance

Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing